lates a much higher antibody response than duck embryo vaccine and at least at this point has *not* been associated with any serious anaphylactic, neuroparalytic or systemic reactions.

Physicians are again reminded that bites from gophers, squirrels, rats, mice, hamsters, rabbits, chipmunks, muskrats, guinea pigs, moles and chinchillas seldom if ever require systemic antirabies treatment. On the other hand bites from animals such as bats, bobcats, coyotes, foxes, skunks and other feral species should be considered as rabies exposure until proven otherwise.

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Malaria Prophylaxis

ON MARCH 10, 1978 the Parasitic Disease Division of the Center for Disease Control (CDC) published a supplement entitled *Chemoprophylaxis of Malaria* which includes recommendations to travelers and a comprehensive review of the agents available. The following is a brief summary:

Chloroquine phosphate is the drug of choice for suppression, that is, prevention of clinical symptoms of malaria by strains sensitive to the drug. The recommended adult dose is 500 mg (300 mg base) taken weekly; 5 mg per kg of body weight base for children taken weekly beginning two weeks before entering a malarious area and continuing for six weeks after leaving. In this dosage, side effects other than gastrointestinal disturbances—headache, dizziness and blurred vision—are rare. These adverse reactions may be reduced by taking chloroquine with meals. Travelers should be told that this regimen may not protect against chloroquine resistant forms.

Chloroquine suppresses the erythrocytic stages of Plasmodium and if the above regimen is followed, Plasmodium falciparum and Plasmodium malariae, which do not persist in exoerythrocytic phases, will usually be eradicated.

Infection with Plasmodium vivax and Plasmodium ovale may persist in the liver and produce delayed attacks. The exoerythrocytic form is eliminated by a two-week course of primaquine, 15 mg daily for adults and 0.3 mg per kg of body weight daily for children. The use of primaquine for prophylaxis should be reserved for travelers heavily exposed to malaria, who do not have glucose-6-phosphate dehydrogenase (G6PD) deficiency. This drug is not recommended for pregnant women.

Cases of chloroquine-resistant P. falciparum have been documented in Panama, South America, India, Southeast Asia, New Guinea and, most recently, in persons returning from Africa. Travelers may consult their health department or the CDC for information about specific countries. A combination of pyrimethamine and sulfadoxine is an effective suppressive agent for chloroquine-resistant P. falciparum. It is not at present available in the United States but may be purchased in other countries. Travelers may start taking chloroquine before entering the malarious area and then take pyrimethamine, 50 mg, and sulfadoxine, 1,000 mg, once every two weeks continuing for six weeks after last exposure in a malarious area. This combination is active against the erythrocytic stages of malaria. Pyrimethamine-resistant strains of P. vivax will not be suppressed. This preparation is not recommended for pregnant women.

As with all medications, travelers are advised to take a sufficient supply with them for the entire trip. Clinicians should remember that the incubation period of malaria may be prolonged for months in persons who have taken antimalarials. Serologies (done by the Center for Disease Control) are useful in cases in which there is a question of mixed infection where primaquine therapy is being considered.

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Joy of the Communal Bath or Don't Go Near the Water

AS HOT TUBS, whirlpool baths and pools become a more regular feature of private and public recreation, clinicians can expect to see the infectious complications of these communal pools. Common offending agents include Pseudomonas aeroginosa, Staphylococcus aureus, viruses including enteroviruses and adenoviruses, and Mycobacterium marinum.

Several outbreaks traced to Pseudomonas aeroginosa serogroup 11 contamination of whirlpools have been recognized. High temperatures and